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A FIELD AMBULANCE WITH THE FOURTH INFANTRY BRIGADE IN GALLIPOLI.

By J. L. Beeston, C.M.G., V.D., L.K.Q.C.P.I., L.R.C.S.I.,
Colonel, A.A.M.C.

The Fourth Field Ambulance, A.I.F., was raised in October, 1914, and consisted of three sections, A, B and C, A comprising men from Victoria, and B men from South Australia, while those in C section came from West Australia. Thirty men from New South Wales were included in A section.

We put in training and recruiting in Broadmeadows, Victoria, first with A section (B joining us later on), until December 23, 1914, and then we embarked, forming part of the second convoy. C section joined us in Egypt.

From February 10 until April 11 we underwent Divisional training. All kinds of manœuvres were practised, such as striking camp and moving to another position and pitching, the idea being that we might have to advance or retire hurriedly. The men were also taught first-aid continuously.

For the attack on Gallipoli we embarked at Alexandria, proceeding to Lemnos, where we remained for ten days. During this time every opportunity was seized to practise landing from boats. Every day all ranks proceeded up and down the pilot ladder in full marching order, going ashore and doing bearer work in the hills round Mudros Bay.

Our transport steamed out of Lemnos in company with the fleet. We carried eight horse-boats, which were dropped at Hellas, where we witnessed the landing of the 29th Division, and afterwards proceeded to Anzac. Each man was issued with two first field dressings besides his own, a yard of India-rubber tubing for a tourniquet and two roller bandages. He carried three days' rations, his water-bottle filled, and a bundle of firewood. Each squad had a set of splints of various sizes. Each officer had a bottle of morphine solution and his hypodermic case.

The next day orders were received for the bearer divisions to land that evening and the tent divisions the following morning. The transport divisions were told to remain on the ship. A trawler conveyed us to the beach, and we soon obtained our baptism of fire. Barges were towed out to the trawler and thence to the beach, where, as soon as they grounded, we jumped out and took up a position in a gully, which afterwards became the headquarters of General Birdwood. The operating tents of each section were brought ashore, together with the equipment and panniers.

On the beach, the casualties were being treated by No. 1 Casualty Clearing Station, the New Zealand Field Ambulance and an ambulance belonging to the Royal Marine Light Infantry.

The Fourth Field Ambulance opened up one section in the gully, in which lightly wounded men were admitted, shelter being made in dug-outs for those for whom there was no accommodation in the tent. The position was very exposed to shrapnel fire, chiefly coming over Pluggey's plateau; but, owing to the peculiar physical features of the country, no more suitable place could be obtained.

All available space soon became full, and the bearers had plenty of work conveying the wounded to the Clearing Station, from which their transport to the hospital ships was undertaken.

A week later the Royal Marine Light Infantry left the Peninsula, and we were ordered to take their place on the beach.

The site was one dug into the cliff, with sandbags over head and on either side, the position being subject to enfilade fire from shrapnel.

Two operating tables were improvised, by setting pieces of 4 × 4 timber in the ground, with cross-pieces, so as to support a stretcher at a convenient height. When the patient came in, he was kept on the stretcher, just as he was, the stretcher forming the table. Shelves for holding instrument trays, etc., were made at convenient places.

We were well equipped with sterilizers, both for dressings and instruments. Asepsis was not practicable; the antiseptic method was followed. We had an abundance of first field dressings, also plenty of wool and gauze. Iodine was used in every case. For fractures we had a plentiful supply of aluminium splinting. Long lengths, 1 in. × ⅛ in., were easily cut with the proper pliers, and a lighter variety for connecting pieces. Properly made, they could be adapted to almost any fracture. A couple of men, carpenters, were kept constantly employed in making back splints, with foot pieces, the timber being obtained from provision boxes.

The panniers contained an average supply of instruments, but ours were considerably augmented by a donation from the Red Cross Society in Newcastle, rendering our equipment in that regard far above the average. The chief shortage was in needles and ligatures. The vast number of cases treated, out of all proportion to what could reasonably have been expected, was responsible for this.

For work at night the lighting was supplied by acetylene lamps suspended from the roof. While the carbide lasted the light was a good one. When this ran out, Dietz hurricane lamps were used.

Meanwhile the bearers were set to work, two bearer subdivisions operating while the third rested. A cook kept a supply of hot water and also had "Bovril," "Lemco" and "Oxo," with milk and biscuits constantly on hand.

During the first fortnight or three weeks abdominal wounds predominated. Some of these were ghastly in the extreme, the contents of the man's pocket being frequently found among the intestines. On one occasion I removed the cap of a shell from behind the bladder.

The remarkable feature about these cases was the comparatively small amount of shock. Frequently

a man would converse and describe the injury; meanwhile, an examination disclosed the fact that a large portion of the abdomen had been shot away. These cases were put on one side after a good dose of morphine had been administered, and the end awaited. When the men got well entrenched, the number of abdominal wounds lessened, and head injuries became the more frequent.

The outstanding feature of military surgery, as compared with that obtaining in civil practice, was the cheeriness and stoicism of the wounded. With scores of cases awaiting treatment, a groan was rarely heard, the chief request was for a cigarette. They invariably took an optimistic view of the situation and never questioned the opinion of the medical officer.

One man, who had compound fractures of both legs, simple fracture of one arm, two bullet wounds in the abdomen and two in the chest, asked me if I thought his leg was broken!

Another, with part of his tongue, lower jaw and cheek blown away, after the jaw had been wired and the wounds dressed, motioned for a piece of paper and wrote that he had a tooth loose!

Regarding the number of cases treated, after an ordinary action from 6 to 6, 184 cases would be an average number. On one occasion we had 54 in three-quarters of an hour. A number of these would have first field dressings on. If no hæmorrhage had occurred and the dressing was properly applied, this would not be disturbed. The work was divided up into day and night duty, two officers being on each night and three during the day, while one looked after the section in the gully. Later, as sickness began to manifest itself, the third section of the Ambulance was opened up and placed in another gully.

The water supply was good, but at times we had to be careful in its use. Occasionally, we used sea water boiled.

The work of the stretcher-bearers was arduous in the extreme. All the wounded had to be conveyed on stretchers by the men, some from a very considerable distance, under shrapnel and machine-gun fire. Many bearers were killed and wounded; at times, owing to the severity of the fire, bearing could only be undertaken at night-time. A system of relay stations was instituted. This relieved matters a good deal. It is not possible to express adequately in words the admirable work the bearer divisions performed. Many a man earned the V.C.

Simpson and his donkey are well known. He belonged to another ambulance, and when he was killed the donkey was taken over by Johnson, one of our men, and used for conveyance of lightly wounded cases.

Only necessary operations were undertaken. In all less urgent cases the patients were sent to the hospital ship. They were placed on a barge by the bearers. The barge was then towed out to a trawler, on which they were taken out to the ship. A report accompanied each patient, including a description of the injury and a statement whether morphine had been administered. The cases were divided into two classes. The lightly wounded men, likely to recover in a fortnight, were taken to Mudros in the Fleet-sweeper. The seriously injured were placed in one of the hospital ships and conveyed either to Alexandria, Malta or Gibraltar.

Towards the end of June and in July sickness became very prevalent, chiefly a form of colitis, with liver complications. Jaundice was frequent, and was accompanied by pronounced weakness. A form of malaria made its appearance. In a number of men tenderness over the liver, with enlargement, was a frequent symptom. Salol relieved a good many, but the majority had to be evacuated to Egypt or Malta.

On August 6 the campaign entered another phase. An attempt was made to take Hill 971. Our position on the beach was taken over by the Second Field Ambulance (Lieutenant-Colonel Sturdee), and we were attached to the left assaulting column, and followed in its rear.

Casualties soon came in great numbers. A tent division was established in a dry creek, the cover of the operating tent being stretched from bank to bank. Panniers were used for operating tables, but the place soon became congested, in consequence of the clearing station for that position breaking down and causing a block. This condition was present for 40 hours. Meanwhile, we had nearly 400 wounded on our hands, and their condition was very miserable. A block of a few hours in the evacuation can be dealt with, but longer than that, when the desire to micturate and defæcate becomes urgent, the misery of the men becomes very great. They were exposed to the sun and also to shrapnel fire, and it is remarkable how "nervy" the poor fellows are once they have been hit and are lying helpless on a stretcher. One man, who had been placed in the gully unknown to me, had a shattered arm and a chest wound. When discovered, his wounds were a heaving mass of maggots. Amputation at the shoulder point was the only means of saving his life. Major Clayton gave the anæsthetic. When last seen, this patient was very comfortable. During this period the Turks shelled the place very heavily, as troops were constantly passing us. This made the place quite untenable. After it was over the headquarters staff despatched a body of men to move us to a more desirable spot, under a hill, and free from shrapnel fire. Stray bullets were all that troubled us, but even then we had men hit while attending cases in the tent. The water problem at times was rather acute, as we were further away from the beach, necessitating the whole of the water being carried a mile or a mile and a half. An idea of the work done may be formed when it is stated that on one night, between 10 p.m. and 2 a.m., eight major operations were performed, besides the dressing of a number of minor cases, the only light being that afforded by a Deitz hurricane lamp.

At one time, when it was hoped we would get through, preparation was made for a possible outbreak of cholera, as it was currently reported that such an eventuality was likely when European troops occupied trenches which had been previously held by Turks. Every man was given an injection of anti-cholera serum, and this ambulance was ordered by Colonel Manders, then A.D.M.S., to prepare for

such a contingency. I put the matter into Major Clayton's hands. He organized a hospital of 100 beds in Canterbury Road, and those who are acquainted with Major Clayton will know that the work was efficiently done. The hospital was used for ordinary sick cases; these were very numerous, mainly, as I have previously stated, colitis and dysentery. Feeding the patients on an appropriate diet was difficult. Condensed milk, corn-flour, arrowroot and rice were plentifully supplied by the Army Service Corps, but drugs were difficult to obtain. The majority of the men had to be evacuated. It appeared as if nothing but change of air and climate was of any avail.

The comfort of the wounded was considerably enhanced through the medium of the Red Cross Society. Before leaving Egypt, General Williams advanced a sum of money, by which we were enabled to make purchases from the various ships lying in the Bay. Later, a man was sent to Cairo, to Lieutenant-Colonel Barrett. He supplied 50 cases of goods, pyjamas, shirts, etc. These were an immense boon. A bale of mosquito netting was also purchased. From the middle of June the flies became almost intolerable, a perfect plague to men wounded. Each bearer had a supply of squares of netting, and this helped to make the condition of the wounded less horrible.

In recruiting for an ambulance, a few points might be stated, which I found very useful.

First, get a good quartermaster; a man who understands his job thoroughly is worth untold gold.

Then select the officers, all having special qualifications. The majors in charge of sections should be capable of controlling men and taking charge in the absence of the commanding officer. A good eye man, a dentist and an officer to act as adjutant. A good adjutant, such as I had, saves an infinity of worry. The officers of the bearer subdivisions should be young, active and keen men, resourceful and capable of withstanding fatigue. The warrant officer should be able to control men, transmit orders and see that they are carried out. A good qualified chemist, who can take charge of all drugs and keep the stocks up. Then a capable clerk, one accustomed to keep records. The transport sergeant must be accustomed to horses and capable of acting in any emergency that may arise through horses becoming restive. When these positions have been satisfactorily filled, make understudies for each, to provide against casualties.

The panniers contain almost everything that will be required. The splinting material might be doubled, thermometers doubled, hypodermic syringes trebled and care be taken that they are efficient (metal plungers are the best). There should be six times as many needles and ligatures as are supplied, and the needles should be examined, in order to ascertain whether they suit the operator's requirements. A large supply of wool and gauze, and also of iodine, is an advantage.

An efficient light for night work is an essential. We had one supplied by Brandt. The "A" to "H" panniers contain a well-selected lot of articles, the carpentering tools being very useful indeed. Active service is responsible for a lot of wear and tear, and in the conditions under which we worked, this was especially the case. As it was frequently necessary to move at night, things were lost or broken. This not only applies to equipment, but also to personal belongings. When we left the transport to land; all our baggage was returned to Egypt. Some of mine is still there. However, this is one of "the fortunes of war."

The personnel of the Fourth Field Ambulance was one of which any man might be proud. Everyone was imbued with a great *esprit de corps*, and at times the endurance of the men was severely tried.

I handed over to Lieutenant-Colonel Meikle when my promotion to A.D.M.S. eventuated, and I was quite satisfied that the unit was in good hands.

The following were the officers who landed on the 27th of April: Lieutenant-Colonel Beeston, Major Jermyn (left 6th June), Major Meikle (afterwards C.O.), Captain Dawson (Adjutant), Captain Clayton, Captain Finn; Captain Welch, Captain Jeffries and Captain Kenny (Officers of Bearer Subdivisions), and Captain B. Finn (Dentist).

Reports of Cases.

NOTES AND COMMENTS ON AN ILLUSTRATIVE CASE OF EPITHELIOMA OF THE LIP.[1]

By **C. E. Corlette, M.D., M.Ch., D.P.H.,**
Surgeon, Sydney Hospital.

For a good many years past I have made it a rule in cases of epithelioma of the lip, no matter how small, not only to remove the primary growth, but to make a clean removal of the submental group of glands, including both sides, and also to clean out the submaxillary triangle on the affected side, sometimes on both sides. In addition, I have, during the past two years, always removed the lower portion of the parotid, with its associated glands, and sometimes also those in the carotid region and under the sterno-mastoid. This is done on general principles, without reference to any fact, except the presence of a primary malignant sore on the lip. Experience shows that gland infection is often present for quite a long time before any enlargement can be detected. If operation be postponed until enlargement can be detected in any of the glands, the prospects of cure by operation are greatly lessened. Nothing short of a complete clean up of the neck, down to the subclavian vessels, is likely to be of any use, and the percentage of cures by radical extirpation will even then, at best, be small, the results being palliative rather than curative.

Judging by the number of people who come to the Sydney Hospital with metastatic infection of glands, and who have had the local lesion only removed, it becomes certain that it is not merely an exceptional occurrence, but a very common practice, even now, with some medical men, to remove epitheliomata of the lower lip by a V-shaped incision, and to leave the glands to chance.

I have said that I have followed a certain rule for many years. That is not quite correct. I have on one occasion departed from this rule in recent years, and this exception we have now an opportunity of considering. It tests the value of the rule, and I think it will be well worth our while to devote a little attention to it, and to the practical questions arising out of it.

On January 10, 1911, I removed a small epithelioma from the lower lip of a man, aged 37 years. The lesion was a little to the left of the middle line, quite superficial, covered with a dry scab, not indurated, and so far as mere physical examination was concerned it could not be described as showing evidence of malignancy. It had been present 18

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on May 12, 1916.

months without sign of increase. No glands were palpable. Unfortunately, no microscopic examination was made in this case, though I quite realized that it might be true epithelioma. No operation was done on the glands.

This man remained perfectly well, as far as known, until January 9, 1915, exactly four years after the operation on his lip. On the date mentioned he was suddenly seized with pain and great swelling on the left side of his neck. The same night a doctor was called in, and he said suppuration was imminent. He was seen daily by the doctor for several weeks, boracic foments being applied to the part for a week, when the swelling seemed to have reduced a little. But it never went away, and, about the second week in February it was opened, and some discharge came out. A little later on a piece of solid-looking material came out, and this was sent away for microscopical examination. The report came back that it was malignant. It is rather remarkable that the doctor was never told about the lip. The patient had forgotten about it, and though there was a mark, it was not conspicuous. The patient came to me on March 25, 1915, presenting a large, rounded, smooth lump in the carotid region, about 2 inches in vertical diameter and 1¼ inches transversely. At the lower part was a reddened portion, with an opening in it through which a thin fluid exuded. On March 27 I operated, making a clean sweep from the base of the skull to the clavicle, and from the middle line to the border of the trapezius. The main growth was practically a necrosed, greatly enlarged, malignant gland, involving the external carotid artery and the internal jugular vein, which had both to be removed. The sterno-mastoid muscle was removed as a matter of course. Sir Herbert Maitland was the first to insist on this as an integral part of such operations, and we should be careful to see that no advertising American thief steals the credit due to one of our own surgeons. The necrotic process had reached as far as the external coat of the vein, and in a short time would probably have been through, causing sudden death by hæmorrhage. I found visibly enlarged glands down almost to the subclavian, below the posterior belly of the omohyoid. About two months after this operation I removed two small subcutaneous nodules from the front of the thorax, just below the clavicle. It is five years and four months after the first operation, and fourteen months after the second, and though still at work, he now presents inoperable metastasis at the root of the neck on both sides, extending into the thorax, and infiltrating the subcutaneous tissue over the front of both clavicles. It is noteworthy that the nodules tend to become cystic at the root of the neck, just as the infected glands did higher up.

As regards the case we have just been considering, there is little need to waste words in pointing a moral. It is one to ponder over. Perhaps it is not the kind one would care to make a series of. And that is the real reason why I brought it forward, for there is evidence that there are even now some medical men who are in fact engaged in producing a series of such cases. The members of the series come up later on to the metropolitan hospitals, often hopelessly inoperable; at other times, though with many odds against anything but a palliative effect, they may be operable.

Dr. J. C. Bloodgood contributed a paper on epithelioma of the lip to *Surgery, Gynecology and Obstetrics*, April, 1914 (Vol. XVIII., 404), embodying the results of experience at the Johns Hopkins Hospital. This paper is full of interest, and is worthy of close study by everyone. What follows is abstracted from his paper, and I cannot claim it as my own, though I entirely agree with his conclusions.

First we may direct attention to some of Bloodgood's figures, noting as a preliminary that what he calls "cure" is a conventional term meaning freedom from recurrence for a period of five years or more.

Out of a series of 200 lesions of the lower lip examined microscopically, only 15 were benign, while 185 were malignant. Some few of the benign lesions had existed for many months.

There were eleven cases of V-shaped excision of the lesion only, without removal of glands. Of these, seven showed cures, three developed gland implication later on, and two of the three were unsuccessfully operated on. The eleventh recurred locally. Bloodgood represents results by percentages, but it should be understood that the total numbers are far too small for mathematical expression as percentages, though it may be permissible for personal use, not for quotation in the literature. There were 33 cases of removal of local lesion *plus* glands. The local lesion was, of course, in every case positive. In 21 of the 33 the glands were negative. Out of this series of 21, one recurred locally, 20 were cured. Bloodgood expresses this as 95% cured. In 12 of the 33 the glands were positive. Out of the 12 cases there were six recurrences in the glands, one of them recurring locally as well. The other six were cured. Bloodgood expresses this as 50% cured. Out of the total number of 33, glands were positive in 37% and negative in 63%. Gland involvement was noted in one case only three weeks after the first appearance of the primary lesion. In other cases gland involvement was not found even after the local lesion had existed many months.

There is distinct evidence that a failure to remove the primary lesion with a sufficiently wide margin at the outset makes a very marked difference in the ultimate result. It does not merely mean postponement of cure, but it more than doubles the death-rate. Among 44 primary cases there were 33 cures (75%), with but three local recurrences, while among 15 recurrent cases there were but 5 cures (33%) and nine local recurrences.

There is absolutely no way to recognize the beginnings of cancer in a lesion of the lip, except by a radical excision of the lesion and the microscopical study of the tissue excised. No matter what the duration of the lesion on the lip, and no matter how small it is, if the microscopical study shows a fully-developed carcinoma of the squamous type, the radical operation on the glands of the neck should be performed. The operation on the glands should be done at what is for the patient the most favourable period. To expose, therefore, a lesion of the lip to X-rays or radium, granting that it may accomplish a cure of the local lesion, subjects the patient to the danger of an operation for metastasis to the glands at a later period, when enlargement of the glands brings him to operation. The experience shown by the figures quoted makes plain what this ultimately means to the patient.

Smokers' burns and warts, which are distinctly precancerous lesions, Bloodgood would treat by removing all causes of irritation, using a mouth-wash of bicarbonate of sodium, and a bland ointment. If not healed in ten days he would excise under local anæsthesia. In another place he says that in an adult over 25 years of age, with a lesion of the lower lip localized at one spot, it will be safer, if this lesion does not heal within one month, to excise it. The danger of delay after one month is metastasis to the glands. Delay after one month means taking gamblers' chances. Among the ten cases in which the disease was of less than three months' duration, and in which five years or more have elapsed since the operation, there has been but one failure to cure. In this case the operation consisted in removal of the lesion of the lip only, and this patient returned two years and eight months later with metastasis to the glands, and was not cured by a secondary operation.

Bloodgood considers that there is only one class of patient in which an exception might reasonably be made to the routine removal of glands, and that is in old and feeble individuals, in whom there is a distinct risk of post-operative death if the radical operation be done. The risk of death by metastasis may be less than the risk of death from operation.

PROFESSOR PAVLOV.

We are pleased to learn, on the authority of *Nature*, that the reported death of Professor Ivan Petrovitch Pavlov, one of the most distinguished physiologists of his time, is not founded on fact. It appears that Professor Eugeni Vasilievitch Pavlov, Professor of Surgery at the University of Petrograd, died on February 12, 1916. The report was published in the *Times*, and, as the Christian names were omitted, it was assumed that the great physiologist had died. Obituary notices appeared in all the leading lay and scientific journals, including *Nature*, the *British Medical Journal* and the *Lancet*. The mistake is pardonable. We trust that Professor Pavlov will treasure the high esteem in which he is held for many years.

The Medical Journal of Australia.

SATURDAY, JUNE 24, 1916.

Cancer of the Ovary.

A discussion of importance has recently taken place at a clinical meeting of the New South Wales Branch of the British Medical Association, and the account which we publish in the current issue will, without doubt, be read with care by gynæcologists and pathologists alike. Professor D. A. Welsh has demonstrated a series of ovarian tumours which he regards as undoubtedly primary malignant neoplasms. On the other hand, Dr. Ralph Worrall questions the correctness of this view, and regards them as cancers secondary to neoplasms in other organs. The practical significance is at once apparent, since the removal of the organ at an early stage might lead to cure if the growth were primary, while the operation would not be justifiable should it be metastatic.

Dr. Worrall is supported in his view by other clinical authorities. Sir John Bland Sutton and Dr. W. S. Stone have both studied this condition at the autopsy *in vivo* and *post mortem*, and base their opinion on the appearances of the ovarian growth and also on the finding of a malignant growth elsewhere. Clinical experience is thus opposed to the histological evidence. Professor Welsh asserts that the structure of these malignant ovarian cystomata is inconsistent with any origin other than the Graafian follicle. Pathologists have long taught that there are two types of primary adeno-carcinoma, *viz.*, the glandular and the papillary. The latter is said to be the more common and invariably to develope from a papillary cystoma. Professor Welsh introduces a new phase into the teaching, namely, that the epithelial cells of the cyst wall are always potentially malignant, and that the clinical malignancy becomes apparent when the hyperplastic process causes the cells to burst the bounds of the peritoneal covering of the organ and to take on an exuberant growth without those indefinite mechanical, biological or chemical inhibitions which kept the neoplasm in check as long as it remained strictly ovarian.

Herbert Spencer has produced some extremely valuable evidence on this subject in the collection of gynæcological specimens in the Museum of University College, London. In the preface to the chapter on "Carcinoma of the Ovary," published in the special catalogue, he points out that carcinoma of the ovary is often bilateral and is sometimes associated with, and perhaps secondary to, cancer of the stomach, intestine, gall-bladder or breast. He gives the description of a long series of primary adeno-carcinoma of the ovary. The majority of European pathologists have claimed that, while ovarian carcinomata are frequently secondary to new growths in the intestines, breasts, gall-bladder and stomach, primary growths of the ovary give rise to peritoneal metastatis more frequently than to any other.

It would thus appear that Professor Welsh and a few others are calling on gynæcologists to reverse their teaching and to admit the primary nature of some and perhaps many ovarian adeno-carcinomata. In order to establish his case, it will be necessary for him to produce evidence that the cells of these malignant ovarian growths are derived from the cells of the normal ovary by division. The proof of the identity of the origin of single cells by their morphological characters, size, shape, amount of cytoplasm, form and relative magnitude of nucleus, will not be generally accepted. It is therefore only by the arrangement of cells into definite types of structure that the origin of cells can be ascertained, save if the histologist could produce a complete series of cells demonstrating a gradual transition from a pre-existing form to a fresh type. Failing this, the only conclusive proof of the primary nature of malignant ovarian tumours would be that whenever a growth possessing the peculiar characters of ovarian neoplasms is met with in other organs, a similar tumour is always to be found in the ovary. The production of evidence of this nature is needed if gynæcologists are to act on the doctrine that ovarian cystomata are potentially malignant.

THE CONTROL OF THE MENTALLY DEFECTIVE.

The problem of the feeble-minded, notwithstanding its complexity and difficulties, involves in its

essence two simple tasks. The first is to effect an adequate control of the mentally deficient individual, so as to safeguard him or her from the dangers of life, and the second is to combat those conditions which lead to the establishment of mental deficiency in the unborn and young. These objectives are difficult to attain, partly because special means are required to discover every deviation from the normal, partly because resistance is raised against too stringent powers to control these unfortunate persons, while laxity is inevitably followed by failure, and partly because as soon as one authority claims the mentally deficient as its proper sphere of action, a host of others attempt to undertake a portion of this public duty. Some years have now passed since the Royal Commission on the Care and Control of the Feeble-Minded issued its magnificent report to His Majesty the King and the Houses of Parliament, and over two years have elapsed since the passing of the Mental Deficiency Act, 1913. Various reports and communications are now available, from which lessons can be drawn as to the best manner of approaching the problem. One of the obvious defects of the methods at present adopted in Great Britain is that there are too many auxiliary bodies concerned in looking after the welfare of the mentally defective child. In Australia, a similar overlapping of departmental activity appears to exist, at all events in some of the States, while in other States the matter seems to be no one's business. In England it was recognized at an early date that the Poor Law was not the proper authority to have charge of this important duty. It was also held that it was to the disadvantage of the sufferers if the care and control were subjected to the Lunacy Commissioners. The education authority was recognized as having just claims within certain limitations, and since the School Medical Officer was frequently the same individual as the Medical Officer of Health in country districts, some recognition was claimed by the Public Health authority and the Local Government Board. Lastly, a host of voluntary associations, aiming at the improvement of the physical and moral condition of the community, sought to intervene in the endeavour to cope with this problem. It will be remembered that the Act of 1913 created a special authority, called the Board of Control, which acted as a central authority, and that innumerable local authorities were entrusted with the actual administration of the provisions.

The care of idiots, imbeciles, feeble-minded persons and moral imbeciles should be handed over to one special body, which has no other duties to perform. Some collaboration with the Education Authority must be effected, since the education of feeble-minded children is a special chapter of their care. It is, however, quite essential that the control shall be primarily a medical control and, consequently, medical practitioners specially trained in psychiatry should be engaged in the work and should direct the control, both of the development of the mind and of the care of the body. It is obvious that the ordinary school medical officer is not usually competent to undertake this task, because few have received sufficient education in psychiatry. Another reason exists for limiting the part to be taken in the control by the Education Authority. According to the British law, the definition of imbecile and feeble-minded person is so vague that no one other than a mental specialist should be permitted to determine whether a given child should be entered into the one or other category. Dr. Langdon Downe goes so far as to suggest that the definition of mental deficiency is so wide that it could be applied to the majority of people. New and better definitions are required, and these definitions should be psychiatric and not legal or popular.

SO-CALLED TROPICAL ANÆMIA.

It is generally recognized that the pallor noted in Europeans living in the tropics is not due to a reduction in the amount of hæmoglobin in the blood, despite the fact that the term "tropical anæmia" has been applied to the condition. It is therefore necessary to change the name of this condition, but before this can be done the actual cause of the anæmic appearance should be ascertained, so that when a new name is found it may be accepted as suitable. This subject was investigated with conspicuous care at the Australian Institute of Tropical Medicine in 1914 by Breinl and Priestley (see *The Medical Journal of Australia*, June 5, 1915, p. 537). From the examinations undertaken by these observers, it transpires that the red blood corpuscle counts of children chosen at random at the Townsville schools was certainly not below the normal for children living in temperate climates. The same applies to the hæmoglobin values. On the other hand, the leucocyte

counts proved to be slightly higher and the Arneth index to be raised. These records are suggestive, but do not provide an explanation for the anæmic look. Dr. W. M. Strong has attacked the problem, and offers a theory which may, on full investigation, be found to coincide with fact.[1] He starts by assuming that if the hæmoglobin content of the blood is not diminished and if there is no local ischæmia, the pallor must be produced by some physical condition of the epidermis or of the sub-epidermal layer of the skin. He points out that the increased activity of the sweat glands presupposes an increased cutaneous circulation and consequently excludes an ischæmia of the capillaries of the skin. Arguing from the standpoint of optical physics, he finds that if the true skin contains at least as much normal-coloured blood as the skin of Europeans in Europe, the whiteness or want of redness must be due to either an increase of the thickness of the semi-transparent epidermis or to the inclusion in the upper layers of the skin of a pigment opaque to red rays. There is no evidence of an increased thickness of the epidermis, and he therefore assumes that a small amount of pigment is deposited in the epidermis of the white man living in the tropics. As the quantity of pigment increases, the white colour gives way to a yellowish-brown. The presence of brown pigment in the skin of white men who are much exposed to the sun is readily demonstrable. Dr. Strong points out that when the pigment is deposited in the deeper layer of epidermis, the resulting tint of skin will be paler than when it is superficially situated. He therefore supposes the deposition of small quantities of brown pigment deep in the epidermis as the cause of the appearance of so-called tropical anæmia. Proof of the existence of pigment should not be difficult to obtain. If this theory is correct, and it certainly has the semblance of probability, the term tropical anæmia would be particularly misleading, since it implies the existence of a condition calling for some form of medical treatment.

[1] "The Causation of So-Called Tropical Anæmia," *Transact. Soc. Tropical Medicine and Hygiene*, January, 1916.

British Medical Association News.

SCIENTIFIC.

At a clinical meeting of the New South Wales Branch, held on May 12, 1916 (see *The Medical Journal of Australia*, May 27, 1916, p. 440), Dr. C. E. Corlette read a paper on epithelioma of the lip. The report of this case will be found on page 499.

Dr. F. P. Sandes stated that in a large number of cases of malignant disease of the lip there was no evidence of any involvement of the regional lymphatic glands. In many cases at the Royal Prince Alfred Hospital, Professor Welsh reported a simple hyperplasia of the glands. He raised the question whether the modern practice was not a little too radical. In referring to the X-ray treatment, he pointed out that little benefit could be expected from it, and that it was capable of doing great harm. He was absolutely against it.

Dr. E. H. Binney agreed with Dr. Corlette that the glands should be removed in all cases of epithelioma of the lip. The removal was rather a prophylactic than a curative procedure. The fact that the glands were frequently free from disease did not detract from the value of the measure.

Dr. Corlette, replying, reiterated his advice to perform the complete operation in every case.

A clinical meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on June 9, 1916, Dr. Sinclair Gillies, the President, in the chair.

Dr. Eric Jeffrey read the notes of a case of *strangulated femoral hernia* complicated by *ruptured ectopic gestation*. These notes will be published in a subsequent issue. There was no discussion.

Scoliosis Due to Fracture of Femur.

Dr. Norman D. Royle demonstrated two femora and a portion of the chest to illustrate an old fracture of the femur and the resultant lumbar scoliosis. The subject was a male, aged 78 years, and the body was an anatomical subject in the dissecting room. Dr. Royle had been unable to learn anything of the man's past history, save that he had showed marked senile decay in recent years, and had been bed-ridden from chronic rheumatism. His attention had been attracted to the scoliosis and by the deformity of the aorta. Both femora were exhibited to show the shortening occasioned by the fracture. To compensate this shortening, the lumbar spine had undergone lateral curvature. The vertrebræ had rotated towards the side of the convexity. The transverse processes were pointing more posteriorly than laterally. Dr. Royle described in some detail the chief characteristics of the spinal and thoracic deformities. He stated that Professor Wilson had arrived at the opinion that the fracture had occurred not more than 10 years before.

Large Ovarian Tumour.

Dr. J. C. Windeyer demonstrated a large *multilocular ovarian tumour*, which had been removed the day before. The patient had been admitted to the Royal Hospital for Women in labour at term. A tumour was found lying to the right of the uterus. The labour had proceeded normally; the fœtus presented in the first position (L.O.A.). The duration of the labour was eight hours. The infant weighed 8 lbs. After the delivery the tumour was found to reach a little higher than a point midway between the umbilicus and the xiphoid cartilage of the sternum. The patient was subjected to operation six weeks after the confinement. The right ovary was removed, and the specimen, which weighed 13¾ lbs., was exhibited. The left ovary was found at the operation to be quite normal. Dr. Windeyer pointed out that there was nothing especially difficult about the operation.

Dr. Ralph Worrall regarded Dr. Windeyer's case as a striking instance of the necessity of examination before delivery. He was emphatic on the point that no woman should go to full time without having been examined beforehand by a competent obstetrician, in order that, when labour set in, there would be no surprises in store. He recalled a case of a similar nature, which occurred in his practice some years before. In this instance the doctor had left his patient after delivery, without having examined the abdomen.

Professor D. A. Welsh demonstrated a series of pathological specimens.

Intrathoracic Aneurysm.

The first specimen was one of *intrathoracic aneurysm*, which Professor Welsh had demonstrated before it had been cut at a meeting held on April 15, 1916 (see *The Medical Journal of Australia*, April 22, 1916, p. 349). The specimen had been embedded in gelatine and frozen. A section somewhat oblique in the antero-posterior diameter had been made. The relations of the various structures could be seen with remarkable clearness, and the excellence of the specimen was enhanced by the preservation of the natural colours. Professor Welsh pointed out that it was a specimen to study carefully rather than to demonstrate. The aneurysmal sac, the point of rupture and the subcutaneous extravasated blood were indicated.

Primary Carcinoma of the Vermiform Appendix.

The next specimen shown was a vermiform appendix, which had been fixed in carbon monoxide formalin solu-

tion and embedded in gelatine. To the naked eye there were no indications of carcinoma in the specimen.

Dr. T. W. Lipscomb gave the clinical history of the case as follows: The patient was a single girl, aged 18, who had had several attacks of pain in the right iliac region during two months previous to admission to hospital. The pain passed off in a few hours after lying down. On May 16, 1916, she had a recurrence of the pain, which persisted and led her to seek medical advice. She was referred to the Lewisham Hospital for treatment, with the diagnosis of sub-acute appendicitis. The temperature was 99°. There was no rigidity of the abdominal muscles and only tenderness on deep pressure. The abdomen was opened on the 17th. A small, hard lump was felt at the base of the appendix. This was thought to be a scybalus. It was necessary to encroach on the wall of the caecum, in order to remove the appendix beyond the lump. No other abnormality was discovered within the abdomen. The small lump proved to be a circumscribed tumour in the wall of the appendix.

On examining the tumour microscopically, Professor Welsh found that it was composed of epithelial cell masses, penetrating deeply into the wall, reaching close to the subperitoneal tissue and expanding the whole structure. It was an *adeno-carcinoma* with scirrhous tendency in structural arrangement. The condition was a very uncommon one, more especially in a young woman of 18 years.

Ovarian Growths.

Professor Welsh demonstrated a series of specimens of ovarian tumours. The first was a cystic tumour and a portion of intestine. The growth was adherent to and apparently incorporated with the bowel, and had the appearance of being a peculiar form of a primary growth of the bowel. On minute examination, however, it proved to be a typical *ovarian cystoma*, showing a minimum of malignancy. The growth rested on the wall of the intestine, and was adherent to it, *i.e.*, there was a true implantation. The cell masses of the cystoma did not penetrate the muscle of the intestinal wall, that is to say, there was no malignant infiltration.

Dr. T. W. Lipscomb said that he first saw the patient in January of 1913 in consultation. She was then 21 years of age. She had been confined two weeks before with her first child, and he was asked to see her on account of a tumour in the lower part of the abdomen. The growth had increased in size since the birth and reached as far as the umbilicus. The abdomen was opened and a large pus sac adherent to the abdominal wall and shut off from the general peritoneal cavity was discovered. The abscess was drained. In September of the same year the abdomen was again opened and a large cystic mass, evidently arising from the ovary, was found. The mass was adherent to the intestines, uterus, omentum and Douglas's pouch. It and the tube were removed as completely as possible. In a few places pieces of the wall were densely adherent to the intestine, and had to be left. Unfortunately, the growth had not been preserved. Six months later he failed to find any traces of recurrence. About 12 months ago her medical attendant stated that there was an indefinite mass to be felt above the pubes, which he regarded as the uterus, omentum and bowel matted together. The patient was apparently in good health and no treatment was adopted.

Dr. St. J. W. Dansey continued the clinical history of the case. He saw the patient in May, 1916. She had been perfectly well until five days before, when she was seized with severe abdominal pain, griping in character and intermittent. The pains became more frequent and intense for four days, and then gradually decreased. The patient had vomited throughout the five days. The vomit at first consisted of ordinary food, but later was a yellow green fluid. The bowels had not been opened for three days, and no urine had been passed for 18 hours. She was partially collapsed, with a rapid pulse and a normal temperature. There was some dulness in the flanks and above the pubes. A large, tense, cystic mass, occupying Douglas's pouch, was found to be continuous with a mass felt above the pubes. The diagnosis of impacted ovarian cyst, causing a mechanical obstruction of the bowel, was made. The abdomen was opened and a semi-cystic tumour, about six inches in diameter, was found jammed tightly into the pelvis, pushing the uterus upwards and forwards. There were several strands of free blood vessels passing from the omentum to the exposed surface of the tumour. The tumour was freed from its position with difficulty and brought out of the wound. It was attached to the wall of the lower part of the ileum. The bowel on the proximal side was distended and on the distal side was collapsed. As the patient's condition was desperate, the bowel was clamped on both sides, the tumour removed and the clamped ends of the bowel fixed at the upper end of the wound. A Paul's tube was inserted into the proximal limb of the bowel. The patient died three hours after the operation.

The next specimen exhibited by Professor Welsh was a *primary bilateral ovarian cyst-carcinoma*. The patient, who had been under Dr. Stewart McKay's care, was an unmarried woman, aged 50 years. She had stated that her abdomen had been getting bigger for six months. When first seen it was markedly distended with fluid. The abdomen was opened, about a gallon of fluid evacuated and two ovarian cysts removed. Dr. McKay did not see any growth in the liver and only a little about the broad ligaments. She died seven days after the operation. Both ovaries were much enlarged, and were very similar in appearance and in size. The substance of the organs was crowded with cysts which had burst through the peritoneal investment, forming abundant papilliform outgrowths. The microscopical structure was adeno-carcinoma. In some places there was distinct cystic tendency, while in others there were dense scirrhous masses. The surface papillæ were formed by identical epithelium to that of the main part of the growths.

Professor Welsh demonstrated another pair of ovaries, with tumours in each, which had been removed from a patient under the care of Dr. G. H. Abbott. The patient had suffered from hæmaturia, which had resisted all treatment. The two ovaries were similar in appearance, although one was larger than the other. In each case *adeno-carcinoma* was discovered on examination.

Professor Welsh then exhibited two ovaries and the uterus removed post-mortem from a woman aged 45. Both ovaries showed connective tissue new growths of the fibrous and muscular tissue, that is to say, *fibro-myomata* with sarcomatous tendency. The last specimen demonstrated was one of adeno-carcinoma of both right and left ovary and a very large adherent cyst of the right ovary.

Professor Welsh pointed out that the three last specimens illustrated the interesting fact that ovaries frequently suffer from new growth apparently in sympathy. No other paired organ in the body was affected in the same way. He held the opinion that it was impossible to believe that the growth in the one ovary had been the starting-point of that in the other. He referred to another specimen, which he had come across in the Museum, in which there was a large primary carcinoma in the one organ and a smaller secondary mass in the other. The pathology of this condition was quite distinct from that of a primary cancer in the uterus which invaded the areas. Professor Welsh emphasized the point he had made at the last meeting in regard to the potential malignancy of all ovarian cystomata. As long as the epithelium was limited by the investment of the organ, the hyperplasia was kept within bounds, but as soon as the cells broke through the peritoneum exuberant growth took place.

Dr. R. Gordon Craig opened the discussion by referring to a case of primary carcinoma of the appendix, which he had seen eight years before in the Mayo Clinic. In the pathological department of this clinic very complete and accurate records were kept. Speaking from memory, he stated that in 5,000 consecutive examinations about 0.17% of all the appendices removed at operation were found to be affected with carcinoma. It was a significant fact that no surgeon had yet described a carcinoma of the appendix which had led to death. He thought that the growth in this region, when it caused death, was actually one of the caecum, involving the appendix, not *vice versa*. It was recognized that in carcinoma of the mamma Nature attempted to strangulate and obliterate the malignant cells. The isolation of the vermiform appendix and its peculiar structure no doubt favoured a similar process, and this explanation might be the true one for the fact that, while carcinoma of the appendix occurred not infrequently, a fatal issue had never been observed.

Referring to the specimens of ovarian carcinoma, he called attention to the fact that the usual teaching was that these growths were not primary but were always implanted on the ovary, possibly because of its peculiar tissues. He was therefore very interested to learn from Professor Welsh that there were no primary foci elsewhere in the abdomen in these cases.

Dr. Ralph Worrall reminded Professor Welsh of a case of primary carcinoma of the appendix which had occurred some years before in his practice. Professor Welsh had examined the tumour histologically, and had given him some micro-photographs of the sections. In his case, the growth was much larger than in Dr. Lipscomb's. He considered that it was much to Dr. Lipscomb's credit that he had detected the growth. He was of opinion that these carcinomata started not in the appendix but in the caecum.

Turning to the ovarian cystomata, he expressed the opinion that they were essentially malignant. He had noticed that Professor Welsh had made no reference to a thorough search having been made of the abdominal organs for a primary growth elsewhere. Sir John Bland Sutton had investigated the pathology of cancer of the ovary with great care, and had come to the conclusion that the growths were nearly always secondary to cancer of the stomach, biliary passages or colon. The most exhaustive study of this subject yet undertaken had been published in the April issue of *Surgery, Gynecology and Obstetrics*, by W. S. Stone. This author arrived at the same conclusion. Ovarian new growths were frequently secondary to primary mammary growths. Dr. Worrall held that no operation for the removal of a breast or stomach tumour should be undertaken before a thorough examination of the ovaries had been made.

Dr. Worrall stated that bilateral ovarian tumours were histologically and clinically unfavourable. He was of opinion that the third specimen exhibited had the naked eye appearances of a fibro-myoma. He had never known an instance of local metastasis from a non-malignant pseudo-mucinous adeno-carcinoma, even when such a cyst had ruptured into the peritoneal cavity. On the other hand, implantation was common from a serous cyst-adenoma or papillary cyst of which an atypical example was on the table.

Dr. Cedric Bowker pointed out that, in the specimen of fibro-myoma the parametrium had an almost gristle-like appearance. He suggested that this change might have some intra-uterine origin . He asked Professor Welsh whether he had examined the parametrium.

Professor Welsh replied briefly. He was interested to hear Dr. Gordon Craig's remark in regard to the infrequency of death from carcinoma of the appendix. In Dr. Lipscomb's case, the growth was situated very near the limits of safety. It would be interesting to watch the future history of the patient. In regard to the question of whether cancer of the ovary was primary or secondary, he stated that, while he held a high opinion of Bland Sutton, he could not accept his opinion of this subject. He was convinced that, in his series of cases, the ovarian growth was primary. There was a transformation of the ovarian tissue itself. In the papillary case the growth could not possibly have been originated from cells transferred from elsewhere. Replying to Dr. Bowker, he said that he had not yet studied the parametrium in the case referred to.

Ruptured Ovarian Cysts.

Drs. T. W. Lipscomb, St. J. W. Dansey and Harold Brown communicated the notes of three cases of acute abdominal symptoms due to hæmorrhage from a ruptured ovarian cyst. These notes will be published in a subsequent issue.

Pes planus.

Dr. R. B. Wade spoke of two cases of *flat foot* of an unusual type. In both cases there was well-marked spasm of the peroneal muscles leading to the deformity. Under anæsthesia the foot returned to the natural position. The condition disappeared after tenotomy of the peronei, but returned later. To effect a cure, it was necessary to resect a portion of the tendon, preferably of the *peroneus longus*.

Naval and Military.

In the 176th list of casualties issued on June 15, 1916, it is announced that Captain W. R. Aspinall is seriously ill, and that Captain G. W. Bray is ill in hospital. Among those who have returned to duty is Major J. M. Y. Stewart.

In the 177th list, issued on June 17, 1916, it is announced that Major P. G. Dane and Captain I. Blaubaum are ill in hospital.

We have been requested by the Principal Medical Officer of the 2nd Military District to publish the following notice:

> "It has been approved by Minister for Defence that a special tropical allowance of 10s. per diem be made to medical officers volunteering for service in Rabaul. The allowance to date from the date of embarkation."

Medico-Legal

THE DIAGNOSIS OF PARANOIA.

A case of considerable interest to alienists has been before the New South Wales Courts for some little time. A man, named W. J. Chidley, was received into the Kenmore Hospital for the Insane on February 18, 1916, under certificates. The magistrate, in ordering his detention, had satisfied himself that the patient was suffering from systematized delusional insanity. Various persons have interested themselves in Chidley's case, and have attempted to induce the authorities to take action to obtain his release. On May 5, 1916, Chidley applied to Mr. Justice Street, Mr. Justice Sly and Mr. Justice Gordon in Banco for a writ of *habeas corpus*, or, in the alternative, for a rule calling upon Dr. C. A. Hogg, the Medical Superintendent of the Kenmore Hospital for the Insane to show cause why an order should not be made under Section 99 of the Lunacy Act, 1898. The rule was granted, returnable in a week.

On May 19, 1916, an application was made before the Chief Justice, Mr. Justice Pring and Mr. Justice Sly to make absolute a rule nisi for a writ of *habeas corpus* directed to Dr. C. A. Hogg, the Medical Superintendent of the Kenmore Hospital for the Insane, calling on him to show cause why W. J. Chidley should not be released. The applicant contended that his confinement was wholly unlawful and improper, on the grounds that he was, and always had been, sane; that there was no sufficient evidence for the Justice directing Chidley to be removed to a Hospital for the Insane; and that the order of the Justice was made without justification, and was *ultra vires*.

In support of the application, Dr. Creed, M.L.C., in an affidavit, deposed that Chidley was reasonable in discussion, and that his release would not be a danger to himself or to others. Dr. Sarsfield Cassidy deposed to having examined Chidley and to the fact that he had failed to detect, after exhaustive tests, any evidence of insanity. Dr. G. S. Thompson also deposed by affidavit that Chidley was sane and that he should never have been incarcerated.

Dr. Hogg, in his affidavit, set forth his reasons for concluding that Chidley was suffering from chronic systematized delusional insanity. The certificates of Drs. Chisholm Ross and Cahill were also put in. Both these gentlemen had certified that Chidley was insane, that he was wanting in a sense of proportion, and that he had a vitiated sense of morality. Dr. Cahill had found that Chidley was unable to refrain from lecturing and publishing his views to the detriment of public morals. It may be explained that Chidley holds the view that erection in the course of sexual intercourse is highly detrimental to the health of the individual, and that the sexual function should be performed without any erection.

The Chief Justice decided that the Court had no jurisdiction to act as a court of appeal from the decision of the magistrate in exercising jurisdiction conferred upon him by the Lunacy Act. It had been urged that the magistrate had issued the order without sufficient evidence. The Chief Justice made no comment on the correctness or otherwise of the opinion formed by the magistrate. He stated that

there was undoubted evidence which would warrant the magistrate in coming to the conclusion. He found that the grounds for the application were mistaken, and the application would therefore be dismissed. Mr. Justice Pring and Mr. Justice Sly concurred.

Later in the same day an application was made to Mr. Justice Simpson in Chambers, asking for an enquiry before a Judge and a jury of twelve persons. The application was refused on May 22, 1916.

At a later date an application was made to the Lunacy Court for a further inquiry under Section 99 of the Lunacy Act, 1898, touching the sanity of Chidley. The case was heard by Mr. Justice Harvey on May 29, 1916.

The evidence in favour of the applicant was given by Mr. Meredith Atkinson, Mr. J. le Gay Brereton, the Hon. Dr. J. M. Creed, M.L.C., Dr. G. S. Thompson, and the applicant. Mr. Merewith Atkinson stated that he regarded that Chidley's theory had been logically argued. He did not agree with it, save in its general relation to greater simplicity of living. He distinguished sharply between logical argument and accurate conclusion. He differed from Chidley in regard to his conclusions. He denied that there was any evidence of the book—"The Answer"—having been written in an indecent spirit. Witness had found that Chidley had read widely and was quite rational. He was an intelligent man and was charitably disposed toward those who, in his view, had persecuted him. Chidley regarded himself as the principal advocate of what he considered as a theory of life that would free the human race from most of the evils under which it suffered. Under cross-examination, he admitted that Chidley had regarded coitus without erection as the central idea of his theory of life.

Mr. le Gay Brereton spoke of his experience of Chidley. He considered him sane, and was of opinion that his writings showed a high moral tone.

The Hon. J. M. Creed, M.L.C., gave an account of his examination of Chidley and of his conversations with him. He considered the applicant as sane as he (witness) was. He had come to the conclusion that, if released, Chidley would not be dangerous to himself or to anyone else.

Dr. G. S. Thompson gave evidence at some length, and was subjected to a most searching cross-examination. He stated that he had examined Chidley for 2½ hours, and had found him perfectly sane, rational, logical, open to reason, and prepared to submit to superior technical knowledge, and stated that he had no delusions whatever. He (witness) did not agree with everything in his book, but considered that passages in it were worthy of consideration. He was questioned at length in regard to physiological and psychological matters bearing on the case. In cross-examination, Dr. Thompson admitted that the only proper attitude to which he could address himself in a consideration of Chidley's theories was to discard the laws of civilization. He was asked if he realized that if he set aside civilization, insanity, as it was regarded at present, would disappear, and, in reply, stated that he considered that civilization was a large factor in the production of insanity.

The applicant's evidence is too voluminous to admit, of being summarized.

The case for the Crown consisted in the production of the evidence of constables and other police officers, to prove that Chidley had not been persecuted, but that it had been necessary to arrest him on several occasions, on account of the contents of lectures delivered in the Domain before an audience including women, girls and boys. The evidence of Mr. J. F. McEachern, M.R.C.V.S., was also called to disprove Chidley's contention that the lower animals carried out sexual conjugation without erection. Mr. J. L. Miller, the head keeper at the Zoological Gardens, confirmed this view.

The medical testimony was given by Dr. A. A. Palmer, Dr. C. A. Hogg, Dr. Andrew Davidson, Dr. Chisholm Ross, and Dr. A. W. Campbell. The evidence of these witnesses was to the effect that, after due examination, they had found that Chidley was suffering from chronic systematized delusional insanity. Dr. Campbell based his opinion on Chidley's belief regarding the sexual act, observance of which he thought would have the most extraordinary effect upon humanity. This belief, witness stated, was totally contrary to his knowledge of medicine, and most of the arguments which Chidley advanced in favour of his belief were equally opposed to his knowledge. The belief rendered Chidley egotistically exalted and intolerant of contradiction and opposition. His delusions and various minor points noted at the examination were the tangible expression of what the witness considered to be a deep-seated and widespread mental disorder. Each of the medical witnesses was subjected to prolonged cross-examination.

His Honour delivered a reserved judgement on June 16, 1916. The judgement is as follows:—

"This is an application of Mr. W. J. Chidley, an inmate of the Hospital for the Insane at Kenmore, for an order for his discharge under the provisions of section 99 of the Lunacy Act, 1898. To obtain that order it is necessary that it should be made to appear to my satisfaction that he is of sound mind. The section appears to throw the onus of proof of sanity on to the patient. Where no relevant evidence is produced, the Court must, in judging that evidence, give the patient the benefit of any doubt there may be as to the condition of his mind.

"This investigation into the question whether a man is of sane mind or not presupposes some sort of standard by which the condition of the mind is to be tested. That standard cannot be one purely relative to the individual under consideration; it must have relation to the mentality or mental processes of ordinary men and women, as we observe them here and now. And the question to be decided is whether the confirmed mental processes of the individual under consideration approximates sufficiently closely to the mental processes observed in the generality of men and women of a similar degree of education and civilization. It is not every abnormality that would justify the Court in finding the subject to be of unsound mind, and different minds are bound to take different views, both as to what degree of abnormality is required to constitute unsoundness of mind in general, and also as to the degree of abnormality that is displayed by the person under consideration.

"In dealing with Mr. Chidley's case, it is necessary to determine first of all that his so-called thesis for the regeneration of the human race is not the nostrum of a quack and charlatan, and his self-appointed mission to preach that thesis to a foolish and perverted generation is not a mere pose. Had I thought that was the case, an order under the section in Mr. Chidley's favour would follow as a matter of course. After listening to him in the box, and reading his books and letters, I have no doubt that he is extremely in earnest, and that he has an unshakable conviction that he has discovered a universal panacea, and that it is his duty to his fellow-men to enlighten them in the face of all opposition, and in defiance of all conventions. It is because of his very earnestness and the tenacity with which he holds to his thesis, that I feel no doubt whatever that Mr. Chidley is not of sound mind. I feel no doubt that his sexual thesis is the pivot of what he calls his philosophy; in my judgement, this thesis has no substantial stratum of reasoning evidence or rationality to support it. I feel no doubt that he is not open to reason on the matter.

"Dr. Thompson, whose championship of Mr. Chidley does great credit to his heart, states that he found him open to reason; if he still seriously thinks that, after reading Mr. Chidley's letters, and hearing his evidence in the box, I can only say, with regret, that I am quite unable to accept his view. I have no shadow of doubt that Mr. Chidley's so-called thesis is a fixed obsession of his mind, colouring the whole of his life and of his outlook on life.

"The witnesses called in support of Mr. Chidley naturally minimized the sex aspect, and emphasized those portions of his book which advocate a return to greater simplicity of life and a revolt from the artificiality of the modern state of society. They are also strong champions for freedom of discussion of problems of sex equally with all other subjects. With much of what they say one can cordially agree, and Mr. Chidley was astute enough from time to time to assert that all he wanted was a hearing from persons qualified to judge his thesis and temperate discussion of his philosophy. I feel no doubt this does not truly represent the condition of his mind. That condition is shown in his letters. He states over and over again that his thesis is proved to the satisfaction of any thinking man. Those who refuse to accept it are ignorant or prejudiced, or both.

"Dr. Thompson suggests in his evidence that Mr. Chidley brought forward to his mind sufficient evidence to justify the investigation of his thesis. That evidence has certainly failed to stand the light of investigation in Court. His

bold assertion on page 2 of the private pamphlet printed for circulation among students that he took this discovery to Professor Gilruth and he verified it, as far as other animals are concerned, is, in my opinion, not true; giving him full benefit of what Professor Gilruth said in the letter referred to, it did not amount to more than this, that in the case of the horse and mare, the horse cannot force into the mare, unless the mare is ready, and that, roughly speaking, the same thing applies to most other animals in a state of nature. That Mr. Chidley should assert that this is a verification of his discovery in the case of animals is characteristic. It must not be forgotten that Mr. Chidley had proved his thesis to his own satisfaction before he wrote to Professor Gilruth.

"In my judgement, a thesis so opposed to the universally recorded experience of the human race in all ages and in all states of civilization accepted by Mr. Chidley as an unassailable dogma, which he has the mission to preach to the whole world on no better evidence than he and his advisers have been able to produce to the Court is an insane delusion; it is in the words of Dercum: a false belief concerning which the patient is unable to accept evidence such as is accepted by ordinary men or by normal minds; that delusion is, in Mr. Chidley's case, chronic and systematized.

"That he at the same time shows great mental lucidity in other matters is characteristic of the disease. It is this peculiarity of the disease that enables persons so afflicted to impress their delusive ideas on others, who become their partisans. I am satisfied that the universal testimony of the mental experts called by the Crown is correct, that Mr. Chidley presents a typical case of paranoia.

"There the inquiry ceases, as far as I am concerned, but I think I ought to add a few words as to the detention of Mr. Chidley in a Hospital for the Insane. This is a matter for the medical men who have charge of the patients in these hospitals. Mr. Chidley's perverted ideas can, so far as one can judge, do no harm to himself. The necessity exists to protect the public from the unreasonable propagation of his gospel and the dissemination of his writings broadcast. If means can be found by which the preaching of Mr. Chidley's gospel can be limited so as to reach only those earnest persons of both sexes who regard Mr. Chidley as an acute thinker and reliable observer, I have little doubt that the hospital authorities will be glad to leave him at large with other monomaniacs whose delusions do no harm and give no offence to the general body of their fellow-men. Whether this is possible I do not know. For Mr. Chidley himself, no one could help feeling the greatest sympathy, having in view his obvious sincerity and singleness of purpose. I suggest to that body of sympathizers who have supported him in the past to consider whether they cannot make some proposal whereby Mr. Chidley's freedom may be made compatible with the preservation of those standards of general public decency which the present conditions of society require. I make no order as to costs."

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending June 10, 1916:—

	Metropolitan Combined Districts.		Hunter River Combined Districts.		Remainder of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever	6	0	0	0	14	0	20	0
Scarlatina	49	1	2	0	76	2	127	3
Diphtheria	67	2	2	1	83	2	152	5
C'bro-Sp'l Menin.	0	1	0	0	4	2	4	3
Infantile Paralysis	2	0	0	0	0	0	2	0
Pul. Tuberculosis	43	14	0	0	†		43	14
Malaria	1	0	0	0	0	0	1	0

† Notifiable only in the Metropolitan and Hunter River Districts.

The four cases of cerebro-spinal meningitis notified during the week occurred in patients aged 28, 21, 15, and 13 years respectively. Two of these individuals were attached to military camps, one at Dubbo and the other at Cootamundra. Two of the patients died. The death recorded in the metropolitan district was of a patient at Randwick, whose infection was reported previously.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending June 11, 1916:—

	Metropolitan.		Rest of State.		Totals.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	72	2	48	1	120	3
Scarlatina	19	0	16	0	35	0
Enteric Fever	1	0	6	2	7	2
Pulmonary Tuberculosis	23	9	6	2	29	11
C'bro-Spinal Meningitis	9	—	38	—	47	—

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending June 10, 1916:—

Disease.	No. of Cases.
Diphtheria	44
Scarlatina	17
Varicella	8
Pulmonary Tuberculosis	8
Infantile Paralysis	1
Enteric Fever	6
Cerebro-Spinal Meningitis	3
Erysipelas	1

We have been asked to state that the firm of Hoffmann, La-Roche Chemical Works, Ltd., of Idol Lane, London, and the parent firm, of Basle, Switzerland, have been labouring under a disadvantage, owing to certain inaccurate information having been received by the Foreign Trade Department of the Foreign Office in London. Representations were made in regard to the matter, and Sir Edward Grey has given instructions that the disability respecting this firm should be removed. We have evidence in our possession that the parent firm is entirely a Swiss firm and that its capital is also Swiss.

Personal.

News has been received that Dr. Robert Aspinall, who was recently reported seriously ill with pneumonia, is now convalescing satisfactorily. Drs. Robert and Eric Aspinall are with the troops on the Canal, Egypt.

Dr. Arthur Aspinall has given up his practice at Nimbin, New South Wales, and enlisted for active service.

Dr. Archie Aspinall, after twenty-two months' military service, is resuming private practice at College Street, Sydney.

Proceedings of the Australasian Medical Boards.

NEW SOUTH WALES.

The following have been registered under the provisions of the "Medical Act, 1912, 1915," as duly qualified medical practitioners:—

O'Brien, John William, M.B. et Ch.B., 1886; Dip., State Med., Dubl., 1887; F.R.C.S., Irel., 1887.

For additional registration:—

Macnamara, Leslie Osborne, M.S., 1916, Univ. Sydney.
Smith, John William, M.S., 1916, Univ. Sydney.
Van Someren, Bertram, M.S., 1916, Univ. Sydney.
Voss, Paul Ernest, M.S., 1916, Univ. Sydney.

VICTORIA.

The following have been registered under the provisions of the "Medical Act, 1915," as duly qualified medical practitioners:—

Morrison, Alexander, M.R.C.S., Eng., L.R.C.P., Lond., 1895, c/o. W. Ramsay, 80 Swanston Street, Melbourne.

Grieve, John Whyte, M.B. et Ch.B., Melb., 1913. 254 Bay Street, Brighton.
Shaw, Harry Charles Costello, M.R.C.S., Eng., L.R.C.P., Lond., 1884, Bank of North Queensland, Queen Street, Melbourne.
Prichard, Nigel Lovat, M.B. et Ch.B., Melb., 1915, 40 Armadale Street, Armadale.
Franklands, Herbert William, M.B. et Ch.B., Melb., 1916, Pennant Hills, New South Wales.

Name of practitioner changed:—
No. 2794. Isaac Judah Silbermann to Isaac Judah Silverman.

Name of practitioner removed from the Register:—
No. 2594. Herbert William Fankhauser (at his own request).

SOUTH AUSTRALIA.

Harry Wyatt Wunderly, M.B., B.S. (Melb.), 1915, has been registered under the provisions of the "Medical Act Amendment Act, 1889," as a duly qualified medical practitioner.

Medical Appointments.

Dr. L. L. Davey, of Adelaide, South Australia, has been appointed Public Vaccinator.

Dr. Kate Neill has resigned her position as Junior Assistant Medical Officer, on probation, at the Lunacy Department, New South Wales.

Dr. Enid Craig Christie Bowman has resigned her position as Junior Assistant Medical Officer, on probation, at the Lunacy Department, New South Wales.

Dr. W. H. Nelson has resigned his position as District Medical Officer of Health, Greenbushes, Western Australia.

Dr. H. Priestley, Quarantine Officer at Townsville, has been appointed an "Officer" under the Immigration Act, 1901-1912, in place of Dr. W. B. Nisbet (resigned).

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

Hobart General Hospital, Junior House Surgeon.
Brisbane Hospital, Resident Medical Officer.
Education Department of South Australia, Medical Inspector.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—New Appointments as Medical Officer, Ophthalmic Surgeon, Ear, Nose and Throat Surgeon, Physician. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

June 27.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
June 28.—Vic. Branch, B.M.A., Council.
June 29.—S. Aust. Branch, B.M.A., Annual General Meeting.
June 30.—N.S.W. Branch, B.M.A., Ordinary.
July 4.—N.S.W. Branch, B.M.A., Council (Quarterly).
July 5.—Vic. Branch, B.M.A., Branch.
July 7.—Q. Branch, B.M.A., Branch.
July 11.—Tas. Branch, B.M.A., General.
July 11.—N.S.W. Branch, B.M.A., Ethics Committee.
July 13.—Vic. Branch, B.M.A., Council.
July 14.—S. Aust. Branch, B.M.A., Council.
July 14.—N.S.W. Branch, B.M.A., Clinical.
July 15.—Northern Suburbs Med. Assoc. (N.S.W.).
July 18.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
July 19.—W.A. Branch, B.M.A., General.
July 21.—Q. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrury be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

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EDUCATION DEPARTMENT OF SOUTH AUSTRALIA.

APPLICATIONS for the position of MEDICAL INSPECTOR will be received up to July 1st, 1916, by the Director of Education, Adelaide. Salary to be at the rate of £400 per annum.

Applicants must be duly qualified medical practitioners, holding degrees recognized in Great Britain and the Commonwealth; should have a knowledge of diseases of children, and have done special work in eye and ear departments.

M. M. MAUGHAN,
Director of Education.

9th June, 1916.

BRISBANE HOSPITAL (QUEENSLAND).

APPLICATIONS are invited for the position of Resident Medical Officer (three vacancies).

A. P. PAYNE,
Secretary.

HOBART GENERAL HOSPITAL.

APPLICATIONS from legally qualified Medical Practitioners to fill the appointment of JUNIOR HOUSE SURGEON to the Hobart General Hospital will be received by the undersigned up till 12 noon on Wednesday, 5th July. Salary, £200 for first year, £225 for second year, and £250 for third year, with furnished quarters (suitable for a single man), fuel, light and water.

Successful applicant expected to hold the appointment for one year. Engagement terminable at one month's notice on either side. Applicants to furnish testimonials and to state age and previous experience, also earliest date able to take up duties if appointed.

W. P. BROWNELL,
Chairman, Board of Management.

June 2, 1916.

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